



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

**Pre-authorization Request Form
DME**

Commercial, Individual, Medicare, BCBS FEP members:

Fax: 1 (855) 232-0090

Administrative Services Only (ASO) members:

Fax: 1 (844) 679-7763

**Mail to: PO Box 1271, WW5-53
Portland, OR 97207-1271**

Instructions: This form should be completed and filled out by the requesting provider. Prior to completing this form, please confirm the patient's benefits, eligibility and whether pre-authorization is required.

Is this for a Medicare Preservice Benefit Organization Determination Request? Yes No

Expedited request. I attest that this request meets the definition indicated below by checking the expedited request box. Fax to 1 (855) 240-6498.

Expedited is defined as: When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

| SECTION 1 – PATIENT INFORMATION | | | | | | | | | | |
|---|--|-----------------|-------|----------|--|--|--|---|-------------------|---------------|
| Patient Name (Last) | | | | | First | | | MI | Patient's Phone # | |
| Patient's Regence Member ID # | | | | | Group # | | | | | Date of Birth |
| | | | | | | | | | | |
| SECTION 2 – PROVIDER INFORMATION | | | | | | | | | | |
| Requesting/Prescribing Provider Name | | | | | Tax ID # | | | | | |
| NPI # | | Office Phone # | | | Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Fax # | | |
| Mailing Address | | | | | City | | | State | ZIP Code | |
| Provider Specialty | | | | | Email Address | | | | | |
| Who should we contact if we require additional information? | | | | | | | | | | |
| Name | | Phone # Ext. | | | Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Fax # | | |
| If a physician reviewer needs a peer to peer discussion before a determination, please provide the treating provider's direct phone number and availability for the next 3 to 5 days. | | | | | | | | | | |
| Phone #: | | Date: | | | Date: | | | Date: | | |
| Ext: | | Time: | | | Time: | | | Time: | | |
| DME Company Name | | | | | Tax ID # | | | NPI # | | |
| Mailing Address | | | | | Fax # | | | | | |
| City | | | State | ZIP Code | Phone # Ext. | | | Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Email Address | | | | | Signed copy of prescription attached: <input type="checkbox"/> Yes <input type="checkbox"/> No Invoice attached: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Service _____

Please check one: Outpatient Hospital Inpatient ASC Office Home
 Other _____

Please provide all diagnosis, CPT or HCPCS codes and their descriptions.

| Diagnosis code(s) and description(s) | CPT or HCPCS code(s) and description(s) |
|--------------------------------------|---|
| Primary: | |
| Second: | |
| Third: | |

SECTION 4 – DOCUMENTATION SUBMISSION

Submit the following documentation, as appropriate, with this request:

- Signed copy of prescription
 - Invoice with pricing
- AND**
- Specific clinical documentation as outlined in the associated Regence Medical Policy, Policy Guidelines section
- OR**
- Specific clinical information documenting the applicable Medicare, or BCBS FEP medical necessity criteria, **including:**
 - History and physical
 - Lab/Radiology/Testing results
 - Current symptoms and functional impairment
 - Treatment history and any other information such as chart notes that support medical necessity for the request

Any other supporting documents you would like considered, such as letters from outpatient providers, etc.